GMPA
Global Migration Policy Associates
An International research, policy development, advisory services, training and advocacy group

BRIEFING NOTE: A PRELIMINARY REVIEW[1]

SEPSIS – migrant and refugee risks and determinants require specific responsive approaches

WHA 78 Side Event: 2030 Global Agenda for Sepsis;
Making the Next Success Story in Global Health
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This brief focuses on Sepsis risks and prevention measures concerning migrants and refugees -- some of whom are in 'high risk' situations for sepsis whether the large majority living and working in urban settings worldwide, or in rural agricultural work, at construction or mining sites, or refugee and IDP camps, In doing so, we address the bigger picture of international migration and mobility, a notable concern for every health system in the world. Every country today counts migrants -- foreign born persons-- as part of its population while significant numbers of many countries' populations live and work abroad.

Reducing sepsis incidence and mortality by 2030 and achieving a global health success story requires directing specific attention to establishing and strengthening appropriate *migrant- and gender-responsive* measures inclusive of all migrants, refugees and other *foreigners*.

The reality context

UN statistics show the global estimate of migrant stock to be 304 million persons in 2024, 3.5% of the world population. The UN data –derived from national reporting and estimations -- counts migrants as *foreign born* persons resident in a country other than of birth or citizenship for one year or more. This includes most of the 30 million refugees, asylum seekers or persons of concern to UNHCR, not including IDPs, There are several tens of millions more migrants--mainly migrant workers at all educational and skills levels, and in some cases family members-- in short term, itinerant, or other temporary situations staying less than a year in a country other than that of usual residence who are not counted in the global migrant stock figure.

80-90% of all migrants reside in urban areas and overall, the majority of migrants are in industrialized countries of the West, notably across Europe, North America, also the Russian Federation, with high numbers in numerous middle income countries in Africa, Asia and Latin America.

[1]This is a preliminary version for circulation to participants at the WHA78 side event on Sepsis. Source citations and references for facts and data cited will be incorporated in a full edition to be put on line and circulated by 30 May 2025

Migrants/immigrants comprise an average of 13% of populations across OECD member counties, around or over18% for Australia, Canada, Germany, Switzerland, the USA and others. Here in the State of Geneva, 40% plus of the population is foreign-born, and a higher proportion of the workforce, adding in the 105,000 *frontaliers* who come to work in the city from a different country of residence every day.

Contrary to standard –and generally demeaning-- stereotypical media and political images of migrants, migrant populations worldwide have overall higher educational levels than the native cohort. Working age women migrants have higher economic activity levels than native-born women while economic activity levels are generally similar between migrant/immigrant men and native born men.

Sepsis risk factors

In Western countries as well as elsewhere, Sepsis risk factors are compounded for immigrants/migrants. Many face remuneration below living wages, greater risk of occupational injury, less access to social protection--notably health insurance or similar coverage, higher barriers to access medical care –lack of insurance, denial or restrictions on access to health care, language barriers and sometimes inter-cultural impediments, adding up to generalized restrictions on realization of the right to the highest attainable level of physical and mental health and health/related rights.

Migrants realization of health rights crucial to prevention of sepsis, are also constrained by increasing prevalence of anti-foreigner anti migrant anti refugee discourse and public policy, as well as notable incidence of anti-foreigner *in-your-face* hostility and outright even deadly violence.

Many migrant workers are concentrated in 3D work, many in sectors with higher risk of accidents, injury and illnesses and or exposure to infectious agents and lack of PPE, namely agriculture, construction, health sector services, cleaning and maintenance, and sanitation, among others.

A huge often unnamed risk factor derives from the greater exposure of migrant workers --foreign workers-- to occupation injury and death. These themselves are a huge factor for sepsis and sepsis control. A 2023 report by the International Labour Organization (ILO) released during the World Congress on Safety and Health at Work, estimated that, annually nearly 3 million workers loose their lives while **395 million workers** worldwide sustain non-fatal work injuries. The sepsis risks entailed are manifestly large and broad, including lack of adequate immediate emergency attention, absence of on site sanitation, distance to or unavailability of hospital facilities, inadequate prevention measures, sanitation protocols, and proper medications in any and all stages of post-accident treatment.

When and where data has been disaggregated, it has shown that foreign worker incidence of workplace injury and death is double that of native born workers in the same work sectors and workplaces.

A large proportion of migrant workers and family members are confined to ghetto type urban living situations in Western industrialized countries and elsewhere, with lack of WASH –*water, sanitation, health and hygiene,* with facilities and medical services and hospitals few and far away concentrated in poorer neighbourhoods, tending to be especially poor in proximity and access to health services, also in water and sanitation services.

A particular sepsis risk factor shown by data is that, for the above factors and related reasons, migrants in uninsured and/or precarious situations tend to go to hospitals or otherwise seek formal medical attention only when they are in ‘last minute’ acute stages of illness and injury, meaning

already subject to infection and immunity-weakened by serious illness or overwhelmed by injury. In parallel, many migrant and refugee women have little or no access to prenatal care, childbirth in any kind of adequate facility, nor post natal care.

COVID crisis and discriminatory responses is a case in point of particular relevance to addressing Sepsis. One one size fits all or exclusionary approaches predominated in countries around the world, both of which exacerbated both risks and mortality

An example: Immigrant and immigrant origin Somalians as a population had among the highest COVID mortality in London if not UK by data disaggregated by nationality and origin. That was due to 3 main factors:
-- many working age Somalians worked in hospitals and other health facilities where they were highly exposed to COVID patients, but they were among the last to get PPE in preventative information;
-- many lived in multi-generational households with aged relatives –while statistics showed from early on that aged persons had remarkably higher mortality;
-- Somalian immigrants, as other immigrant populations, were concentrated in high density living spaces in poor quality, indecent housing in neighbourhoods of deteriorated, sub-standard buildings.

Existing literature

There is considerable medical research and other literature addressing sepsis and refugees, migrants and displaced persons. However, much more needs to be done. In an initial survey, it appears that much of the extant literature conveys partial and skewed understandings of migrants and migration – and consequently of factors and approaches to appropriately address Sepsis risks and responses for migrants and refugees. Among lacuna are:‘

- difficulty distinguishing refugees and migrants as well as collapsing distinctions between persons displaced with their country of nationality/residence versus abroad across borders.
- characterising migration itself as major risk factor
- associating *3rd world* origins as generally characteristic of migrants
- predominance of attributing *vulnerability* descriptors to migrants and refugees, rather than appropriate terms of risk and at risk that both recognizes persons and group agency and focusing on the in-fact predominance of social, economic, environmental, legal and political risk factors and determinants –that are far more determinant of poorer health outcomes in generalas a whole and sepsis in particular than individual characteristics, origins or behaviour.

Further situational factors relevant to addressing sepsis

The majorities of migrants and migrations are within regions, indeed within economic communities and or neighboring countries and regions. For example, over 80% of migrants in Europe originate in other European countries including EU candidate countries and the Balkan states, even higher including BEL, UKR, RF and Turkey, as well as Australia, Canada, New Zealand and the USA. Similarly, some 80% of migrants in ECOWAS Economic Community of West African States originate from other ECOWAS member countries, as is the case for the Eurasian Economic Union -- EAEU.

Yes, a big concern remains with refugees –but these comprise some 30 million out of the 300 million counted migrants worldwide. Regarding refugees, particular concern is merited for the 6 million Palestinians counted under care of UNRWA and the 2 million now displaced persons in Gaza where hospitals have been pulverized, health workers targetted, ambulances blown up with their crews, and medicines including antibiotics kept out. There are huge issues with Sepsis there, but elaboration is beyond the scope of this brief.

A Sepsis Agenda addressing Migrants and Refugees

The anti-sepsis agenda for migrants and refugees as well as IDPs, comprises targeted outreach and interventions needs to include:

- health education for all with outreach to immigrant groups, communities,
  - of course including mention of sepsis specific risks, prevention and responses
- providing sepsis and related knowledge regarding immigrant, migrant, refugee, foreign populations in training for health professionals at all levels as well as in research
- info and interventions in languages people can understand
- enhancing proximity of primary health care services
- focus on occupational safety and health risks and prevention, targeted labour inspection and enhanced public health cooperation.

In broad terms, these intersect with and necessarily reflect:

- concretization of universal health care
- public health policy explicitly inclusive of all, with specific approaches for all distinct groups and populations
- generalization of WASH approaches throughout all cities as well as rural areas
- strengthening adoption and implementation of international occupational safety and health standards applicable to all workers and workplaces in the country

In complement, the challenge here is for the Sepsis Alliance and WHO as well as health institutions globally to give targeted attention to conducting well-grounded research and establishing appropriate policy on migrant-responsive components for the overall global effort to reduce-sepsis incidence and mortality.

This agenda of course coincides with the five main strategic pillars of the *2030 Global Agenda for Sepsis*, and should be integrated into elaboration and implementation of that Agenda.

Additional points as well as reference sources and citations to be added

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